

1. Overview of Billing

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1.1 About the Revenue Operations Manual

The Indian Health Service *Revenue Operations Manual* provides a system-wide reference resource for all Indian, Tribal, and Urban (I/T/U) facilities across the United States, to assist any and all staff with any function related to business operation procedures and processes.

1.1.1 Revenue Operations Manual Objectives

- Provide standardized policies, procedures, and guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all of IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest quality of service at each level of the Business Office operation.

1.1.2 Revenue Operations Manual Contents

The *Revenue Operations Manual* is divided into the following five (5) parts:

- **Part 1 Administrative Roles and Responsibilities** contains
 - Overview of revenue operations
 - Laws, acts, and regulations affecting health care
 - IHS laws, regulations, and policies
 - Health Insurance Portability and Accountability Act Privacy Rule
 - Business Office management and staff
 - Business Office Quality Process Improvement and Compliance
- **Part 2 Patient Registration** contains:
 - Overview of patient registration
 - Patient eligibility, rights, and grievances
 - Direct care and contract health services
 - Third-party coverage

- Registration, discharge, and transfer
 - Scheduling appointments
 - Benefit coordinator
- **Part 3 Coding** contains:
 - Overview of coding
 - Medical record documentation
 - Coding guidelines
 - Data entry
- **Part 4 Billing** contains:
 - Overview of billing
 - Hard copy vs. electronic claims processing
 - Billing Medicare, Medicaid, and private insurance
 - Third party liability billing
 - Billing private dental insurance and Pharmacy
 - Secondary billing process
- **Part 5 Accounts Management** contains:
 - Overview of accounts management
 - Electronic deposits and Remittance Advices
 - Processing zero pays, payments, and adjustments
 - Creating payment batches
 - Reconciliation of credit/negative balances
 - Collections and collection strategies
 - Rejections and appeals

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

This manual also includes:

- Acronym dictionary
- Glossary

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for downloading, viewing, and printing at this website:

<http://www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm>

Clicking the “Revenue Operations Manual (ROM)” option on the left panel menu, displays the Revenue Operations Manual web page.

1.2 About the Billing Process

Indian Health Care Improvement Act, P.1.94-437, authorizes the Business Office to bill and collect reimbursement from a patient's health insurance and other third party resources. Title IV of the Indian Health Care Improvement Act, as amended, authorizes Indian Health Services facilities to bill and receive payment from Medicaid and Medicare patients. Public Law 100-713 of the Indian Health Care Improvement Act Amendments of 1998 allows IHS to bill and seek payments from private insurance companies and has ruled IHS has the statutory right of recovery.

For an overview of how IHS and Tribes are paid for services rendered to patients in IHS facilities, see Part 4, Appendix A. "IHS Reimbursement Methods."

1.3 General Billing Policy Statement

The third party billing policy for the Business Office is to optimize collections efficiently and effectively from Medicaid, Medicare, private insurance, and other alternate resources in compliance with the rules and regulations of the Centers for Medicare/Medicaid (CMS) and IHS and Third Party Accounts Management and Internal Controls policy.

To have a successful claims management process, everyone in the third-party billing process must perform their specific duties accurately, cooperatively and timely. All necessary steps will be taken to ensure that follow-up on every third party account is adequately and appropriately performed in a timely manner. All IHS facilities will be made aware that collecting third party revenue is a cooperative organizational effort.

1.4 General Billing Guidelines

- All fee schedules need to be reviewed and updated yearly. The Custom Fee Analyzer can be purchased and used as a guide for reviewing the outpatient fee schedule for the facility.

The Analyzer begins with a detailed process on how to review the facility's fees. It is recommended that once a fee schedule is established by the facility that it is used for all payers. To review codes other than outpatient, use either the HCPCS or Dental Analyzer.

- All diagnoses affecting the current treatment of the patient must be included on the claim forms.

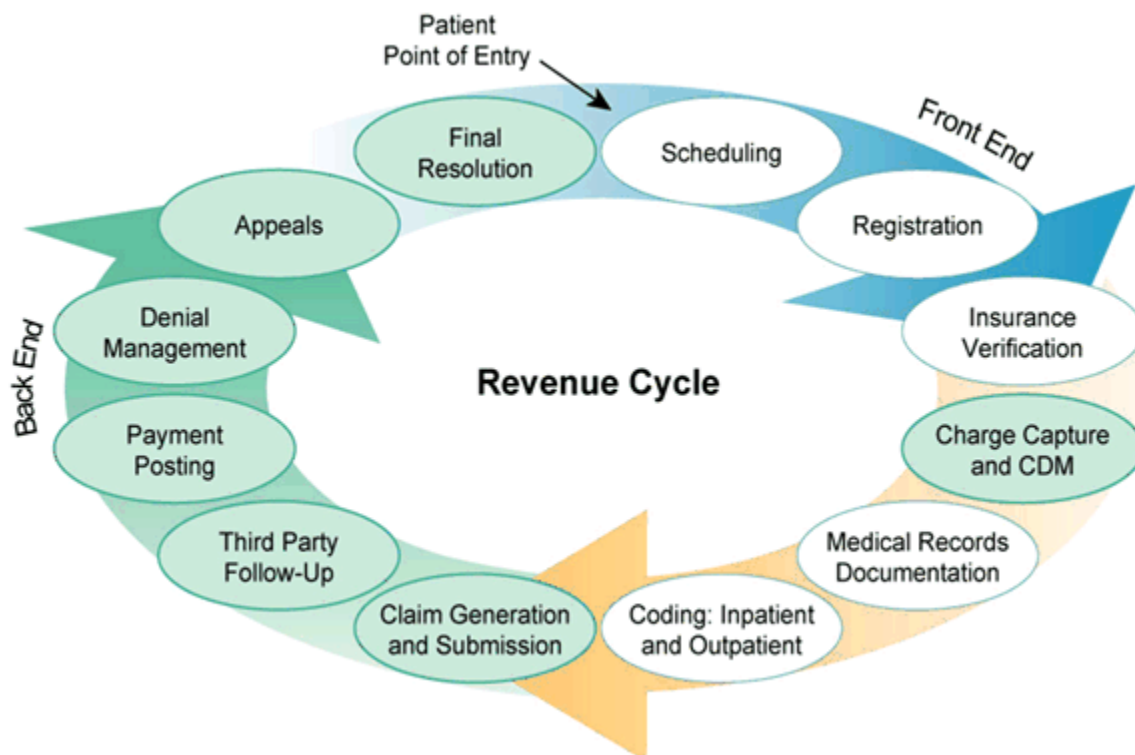
Diagnosis codes (ICD-9) need to be selected with care. All coding must be accurate, precise, and meaningful to guarantee prompt and accurate payment.

- The health care providers will be responsible for providing either the narrative for the diagnosis or in selecting an accurate code that matches his/her written description.
- The coders will code the applicable code and enter all codes into the RPMS system.
- The provider will provide written documentation of the diagnosis and ICD9 code either on the PCC form or in the Electronic Health Record.
- Depending on the facility, the coder or biller will validate the provider's coding.
- A coder or biller should never modify documentation by a provider. If a provider fills out a charge ticket and signs it or completes an EHR with an electronic digital signature, then that document is a legal record and should not be altered.
- If the diagnosis code listed by the provider differs from the coder/biller, the coder or biller must review the discrepancy with the provider. If the provider agrees with the coder/biller, the provider must change the code and initial the claim (either the PCC or as an amended claim in the Electronic Health Record).
- All Medicare, Medicaid, and private insurer claims require a linkage or a relationship between the CPT and ICD-9-CM codes.
- Current Physician Terminology (CPT) is required by most insurers. Procedure codes need to be routinely checked or validated against the diagnostic codes to assure reimbursement is made only for those procedures that are "medically necessary" for the treatment of the stated diagnosis. Either the coder or biller, depending on the facility, should validate the CPT codes for accuracy.
- Claims are processed to the insurer according to the terms set forth in the benefit plan. After receiving the claim, the plan may:
 - Verify the patient's coverage type
 - Verify the services provided are covered
 - Verify services meet Plan requirements
 - Verify pre-certification was required and/or obtained.

- Billing must be familiar with the requirements, benefits, and exclusions for each insurer. AR must also follow-up on all rejected, unpaid, or denied claims within the stipulated timeframe for each insurer

1.4.1 Guidelines to Improve Reimbursement

The organizational flow of information and accurate documentation and coding is crucial to processing third party claims, as illustrated in the Revenue Cycle.



To prevent claims from being rejected, the business process needs to review such areas as:

- inaccurate or lack of coding
- incomplete claims
- lack of supporting documentation
- poor communication with the payer
- not billing for services rendered

The overall reimbursement process is a series of sequential or interconnected but independent steps, starting with the patient's visit to the facility. The steps involve:

- Assuring that all patients are registered for scheduled or walk-in appointments.
- Obtaining accurate and detailed insurance and demographic information during the registration process.
- Accurately documenting the service, examination, and patient care by all providers (physician, mid-level practitioner, nurse, or others).
- Capturing and coding correctly all reportable and billable services.
- Billing all billable services that are not only reimbursable by the insurance company but also supported by documentation.
- Reconciling claim payments to assure correct payment.
- Appealing all rejections that should have been paid.

1.5 Capturing all Reportable and Billable Services

It is important to assure that providers document all services and procedures in the clinical record and enter the applicable codes into the EHR or the RPMS PCC application. To accomplish this, the Business Office should:

- Devote time each week to learn more about billing and coding for services, to acquire enough knowledge to identify all reportable services, procedures, and even supplies.
- Keep current with all the updates from the insurers, for example, MedLearn Matters, CMS newsletter, Medicaid Newsletters, and others.
- Conduct peer review and track the reasons of all rejections or denials. This would include registration, coding, data entry, provider, billing, and accounts receivable. This would determine if errors are identifiable and can be reduced or corrected in the future.
- Make sure the providers document all the services and procedures. This information should be entered into the EHR by the provider or thoroughly documented on the superbill, PCC or PCC+. Documentation should include the E&M level of service, diagnosis, date of services, procedure, patient name, location, and any other pertinent demographic information.
- Educate providers with current billing changes.
- Understand billing requirements for bundling and unbundling of services.

- Examine coding options such as whether to use CPT or HCPCS level II or Level III codes for procedures and services. Carriers or insurer payer policies may dictate what procedure codes or combination of codes to submit.
- For a date of service when multiple surgical procedures are involved, sequence each procedure. The first procedure should be the primary reason for the surgery, and other surgical procedures become secondary. After sequencing, then add the appropriate modifier.
- Link all diagnosis codes or symptoms to the relevant procedures or services. Linking addresses the medical necessity question, supports the services provided, and relates the reason for each service.
- Understand or analyze reports associated with the billing process such as EOB, ERA, RPMS reports, CMS top-ten error reports, and RTP reports.
- Report all software issues promptly to the supervisor.

1.6 About the CMS-1450 / UB-92 Form

The CMS-1450 form, more commonly known as UB-92, serves the needs of many payers. Not all of the data elements need to be completed for every payer.

Data elements in the CMS uniform electronic billing specifications are consistent with the CMS-1450 form data set to the extent that one processing system can handle both. Definitions are also identical. However, due to the space constraints on the form, the electronic record contains more characters for some items than the corresponding items on the form

The revenue coding system for both Form CMS-1450 and the electronic specifications are identical.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the hard copy UB-92 or Form CMS-1450, CMS will accept claims of up to 9 pages. In addition, effective October 16, 2003, all state fields will be discontinued and reclassified as reserved for national assignment.

For descriptions of the locator fields, see Part 4, Appendix B,” CMS 1450/UB-92 Form.”

1.7 Modifiers and their Role in Billing

Modifiers are used to modify payment of a procedure code, assist in determining appropriate coverage, or otherwise identify the detail on the claim. The use of modifiers ensures the appropriate reimbursement by the insurer.

Modifiers are entered in box 24 D on the HCFA-1500 (CMS-1500) claim form or UB 92 (CMS 1450).

For the most current list of modifiers, refer to the current CPT or HCPCS Code book.

Note: The modifiers are updated on a yearly basis, and the tables are supplied to each RPMS site by the IHS Office of Information Technology (OIT). It is the responsibility of each Area IT to install the updated tables.

1.8 Place of Service

Place of Service is a two-digit indicator assigned by CMS to the various places where a medical service or procedure can be provided.

- 03 - School
- 04 - Homeless Shelter
- 05 - Indian Health Service Free-standing Facility
- 06 - Indian Health Service provider-based Facility
- 07 - Tribal 638 Free-standing Facility
- 08 - Tribal 638 Provider-based Facility

- 11 - Office
- 12 - Home
- 13 - Assisted Living Facility
- 14 - Group Home
- 15 - Mobile Unit

- 20 - Urgent Care Facility
- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room, Hospital
- 24 - Ambulatory Surgical Center
- 25 - Birthing Center
- 26 - Military Treatment

- 31 - Skilled Nursing Facility
- 32 - Nursing Facility
- 33 - Custodial Care Facility
- 34 - Hospice

- 41 - Ambulance, Land
- 42 - Ambulance, Air or Water
- 49 - Independent Clinic

- 50 - Federally Qualified Health Facility
- 51 - Inpatient Psychiatric Facility
- 52 - Psychiatric Facility Partial Hospitalization
- 53 - Community Mental Health Center
- 54 - Intermediate Care Facility/Mentally Retarded
- 55 - Residential Substance Abuse Treatment Facility
- 56 - Psychiatric Residential Treatment Center
- 57 - Non-residential Substance Abuse Treatment Facility

- 60 - Mass Immunization Center
- 61 - Comprehensive Inpatient Rehabilitation Facility
- 62 - Comprehensive Outpatient Rehabilitation Facility
- 65 - End-Stage Renal Disease Treatment Facility

- 71 - State or Local Public Health Clinic
- 72 - Rural Health Clinic

- 81 - Independent Laboratory
- 99 - Other Unlisted Facility

The place where a service is rendered can determine the reimbursement and coding conventions applied to the service codes.

If services are rendered in two locations in a given day, such as the clinic and the emergency room, the reimbursement is reduced for the services provided or split into technical and professional components. For the latter, usually two separate bills are provided by the facility.

1.9 “Incident To” Services

“Incident To” services are defined as services commonly furnished in a physician’s office, which are

- incident to the professional services of a physician or a non-physician provider’s employee
- limited to situations in which there is direct physician/non-physician personal supervision.

This applies to auxiliary personnel employed by the physician/non-physician, which includes but is not limited to, nurses, technicians, therapists, non-physician practitioners, and others.

“Incident To” rules apply to all insurers.

To have the same service covered as “incident to” the services of a physician, it must be performed under the direct personal supervision of the physician as an integral part of the physician’s personal in-clinic service. This does not mean that for each visit the patient must also see the physician. It does mean there must have been a direct, personal, professional service furnished by the physician/non-physician to initiate the course of treatment. There must also be subsequent services by the physician/non-physician of a frequency that reflects his/her continuing active participation in, and management of, the course of treatment.

There are four things that are required to qualify for “incident to”:

- 1) The physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist must be an employee of the physician or of the entity which also employs the physician.
- 2) The physician has to have initially seen the patient.
- 3) The physician has to have direct supervision; the physician has to be within the facility, but not necessarily in the same room and must be available to render assistance and direction if necessary.
- 4) The physician must have an active participation in the on-going care of the patient.

1.10 Billing Form Review

The forms you use to bill depend on payer requirements. Prior to submission, review your paper claim forms (e.g., CMS 1450, CMS 1500, ADA, NCPDP, etc.) to ensure that the form locators are completed, based on specific payer requirements.

For information on the CMS 1500 form, go to this website:

<http://www.nucc.org>

For information on the CMS 1450 (UB-92) form, go to this website:

<http://www.nubc.org>

1.11 Utilization Review

Authorization numbers from insurers need to be obtained and are required on the bills when they are generated for billing. Utilization review needs to assure that all billable services have been captured to bill for acute care days and ambulatory care services. The purpose of the process is to assure each facility meets hospitalization and length of stay criteria.

Utilization staff, in this process, needs to work closely with Admitting, Billing, providers, and Coders.

1.11.1 Splitting Claims Process

Hospital billing is split with professional services on the HCFA-1500 form, and the hospital charges, (e.g., lab, pharmacy, radiology, anesthesia, emergency room provider, nurse) and supplies on the UB-92.

Splitting claims is payer specific. For example:

- Split lab for technical and professional
- DME and medical

For more information, see the *RPMS IHS Third Party Billing (ABM) User's Manual*, which is available at this website:

<http://www.ihs.gov/cio/rpms/index.cfm?module=home&option=documents>

1.12 Roll-Over/Cross-Over for Secondary and Tertiary Billing

Medicare currently has contractual arrangements with supplemental insurers to automatically crossover claims payment information for their policyholders. An eligibility file furnished by the supplemental insurer is used to drive the process rather than information found on the claim. These eligibility files are matched, based on the Health Insurance Claim (HIC) number, against Medicare's internal eligibility file. If a match occurs, the beneficiary's record is flagged indicating to which company we will cross claim payment information.

The name of the crossover insurance company will appear on both the beneficiary Explanation of Medicare Benefits and the provider's Remittance Notice.

Users need to ensure the crossover payment was forwarded to the correct secondary payer by reviewing the remittance advice.

Each supplemental insurer is given the opportunity to specify criteria related to the claims the insurer wants Medicare to crossover. Examples of claims most often excluded from the crossover process:

- Totally denied claims
- Claims denied as a duplicate or for missing information
- Adjustment claims
- Claims reimbursed at 100%
- Claims for dates of service outside of the supplemental policy's effective and end dates.

As part of the CMS process, it is required for each service furnished by the provider that the provider reports each service as a separate line item on the claim form.

As claims are processed, the beneficiary's eligibility record is checked by the system to determine whether the claim should be considered for crossover. If the beneficiary's eligibility record is flagged for crossover, the claim is then checked by the system to determine whether the claim meets the crossover criteria required by the insurer. If the claim is not excluded, at this point it is marked for crossover to the appropriate company. An electronic claims payment record is then created and forwarded to the requesting insurer. This eliminates the need for the billing office to file claims for the patient's supplemental benefits.

Upon receipt of the transmittal crossover file, the system will initially edit the file and return a flat file to the contractor indicating the number of claims received and accepted. The entire file that contains any transmission error will be returned with a request for retransmission.

In regard to crossovers, Medicare cannot add, change, or delete any eligibility information furnished by an insurer. In addition, the crossover process is totally automatic, and does not require or permit any clerical intervention.

The crossover insurance companies send an eligibility tape at least once a month to the primary insurer. The crossover company's eligibility tape reads the internal eligibility record and looks for the HIC matches.

The Medicaid update process is the same as the automatic crossover process except the eligibility tape is sent to the primary insurer by each state